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No. 93-2076

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1994

BABY K, THROUGH HER GUARDIAN *AD LITEM*,
MR. K. AND THE HOSPITAL,
Petitioners,

v.

MS. H,
Respondent.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Fourth Circuit

BRIEF FOR THE RESPONDENT IN OPPOSITION

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JULY 27, 1994

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QUESTION PRESENTED

Whether the court of appeals correctly found that the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, requires the petitioner Hospital and its physicians to provide to Baby K stabilizing medical treatment for her emergency medical condition of respiratory distress as requested by her mother, Ms. H.

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BRIEF FOR THE RESPONDENT IN OPPOSITION

STATEMENT OF THE CASE

The basic question presented in this case is whether the Hospital can refuse to provide mechanical ventilation to a child where that treatment has been requested by the child's mother, and where that treatment is effective in treating the child's episodes of respiratory distress, based on the Hospital's view that it is "inappropriate" to save the child's life because of her congenital defect of anencephaly. Both the district court and the court of appeals held that the Hospital's refusal to provide the requested treatment to Baby K would violate the plain language of the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (1988 & Supp. IV 1992).

EMTALA requires hospitals that participate in the Medicare program to provide "such treatment as may be

required to stabilize" an emergency medical condition. *Id.* § 1395dd(b)(1)(A). An "emergency medical condition" is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in . . . serious impairment to bodily functions . . . ." *Id.* § 1395dd(e)(1)(A). "To stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result . . . ." *Id.* § 1395dd(e)(3)(A). The Hospital has admitted, in both its Complaint and the Stipulation of Facts below, that: (1) when Baby K has presented in respiratory distress, "[h]er condition was such that the absence of immediate medical attention could reasonably be expected to cause serious impairment to her bodily functions" (J.A. 23, Complaint ¶ 39; J.A. 471, Stip. ¶ 27); and (2) physicians will have to provide Baby K with ventilation "in order to assure, with reasonable medical probability, that no material deterioration of Baby K's condition is likely to occur if the infant is to be transferred back to [the nursing home] or sent home" (J.A. 24, Complaint ¶ 40; J.A. 471, Stip. ¶ 29).[1/]

The plain language of EMTALA and the Hospital's conforming admissions of fact make this a simple case. The court of appeals correctly applied the statute to the particular facts of this case and properly declined to fashion a judicially-created exemption to the statute enacted by Congress.

A. Factual History

Baby K is almost two years old. She was born on October 13, 1992, to Ms. H at the Hospital. Baby K was diagnosed as having anencephaly, a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. Lacking a functioning cerebral cortex, Baby K is permanently

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1/ "J.A." refers to the Joint Appendix filed in the court of appeals.

unconscious. She cannot see or hear. Baby K cannot feel pain.[2/]

Baby K has a functioning brain stem. Because her brain stem functions, she is alive under the laws of Virginia and all other states.[3/] She has respiratory reflexes (breathing), feeding reflexes (sucking, swallowing, rooting), and reflexive responses to noxious stimuli (avoidance, crying). Baby K has normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function. Notwithstanding the Hospital's repeated characterization of Baby K as a "dying" infant (Pet. 2-5, 9), Baby K has grown and gained weight since her birth.[4/]

On several occasions throughout her life, Baby K has required mechanical assistance to sustain her breathing. On March 15, 1993, doctors at the Hospital performed a tracheotomy on Baby K in order to make it easier for her to breathe on her own. The tracheotomy also made intubation (the process of placing a breathing tube down the trachea) unnecessary for Baby K in the future. As a result, if Baby K again requires mechanical ventilation, all that will be required will be the attachment of an air bag to her already-existing endotracheal tube.

Baby K currently lives at a nursing home near the Hospital. Baby K resides at the nursing home for months at a time without requiring emergency medical attention. Pet. App. A9-A10.[5/]

[2/] These and other facts were stipulated by the parties and are also findings of fact by the district court. The Hospital did not challenge the district court's findings of fact in its appeal.

[3/] *See, e.g.*, Va. Code Ann. § 54.1-2972 (1988 & Supp. 1994).

[4/] The Hospital relies on an article written by a non-physician (Pet. 4 n.3) for the proposition that most anencephalic babies die at birth and that Baby K may be the longest-lived anencephalic infant in medical history. At trial, however, Ms. H's medical expert, Dr. Byrne, testified that it is unclear how long anencephalic infants can live. J.A. 316. Dr. Byrne further testified that he has personal knowledge of at least one anencephalic child who lived to be four-and-a-half years old. *Id.* at 317.

[5/] The nursing home first accepted Baby K in November 1992.

The medical judgment of the Hospital's physicians is that Baby K will again require emergency care -- specifically mechanical ventilation -- at some time in the future. The Hospital has conceded that when Baby K's respiratory distress reoccurs, the absence of immediate medical attention in the form of ventilation could reasonably be expected to result in her death or in serious impairment of her bodily functions. Pet. App. A6-A7, B6; J.A. 471 (Stip. ¶ 27). Nevertheless, the Hospital asserts that it is not required to provide ventilation, or other emergency medical care, to Baby K. The Hospital argues that, even though such treatment will assist Baby K's breathing and extend her life, it will not cure her anencephaly and is therefore "futile" and "inappropriate." The Hospital has stipulated that it is not proposing to deny the requested treatment because of any lack of adequate resources or any inability of Ms. H to pay for the treatment. Pet. App. B4-B5; J.A. 472 (Stip. ¶ 37).

Throughout the approximately two years since Baby K's birth, Ms. H has remained very much involved in her daughter's care. The Hospital sought her consent for all medical procedures performed on Baby K and never sought the consent of Mr. K, the child's father. Mr. K was uninvolved during Ms. H's pregnancy, was not present at Baby K's birth, and has paid very little attention to his daughter since her birth. Indeed, the district court concluded as a finding of fact that Mr. K "has, at most, been only distantly involved in matters relating to" Baby K, and that "[n]either the Hospital nor Ms. H ever sought Mr. K's opinion or consent in providing medical treatment to Baby K." Pet. App. B2. Nevertheless, Mr. K has taken the position that ventilator treatment should not be provided to Baby K in the future.

In contrast, Ms. H wishes to sustain Baby K's life for several reasons, including her strong religious belief that all life has value and should be preserved. Ms. H also believes that she -- as the mother and legal guardian of Baby K, and as the only parent who has participated in the baby's care -- has the legal and moral right to decide what medical treatment is in Baby K's best interests. It is undisputed that the provision of mechanical ventilation will extend Baby K's life by alleviating

her episodes of respiratory distress, although it will not cure her anencephaly.

B. Procedural History

Following Baby K's birth, the Hospital repeatedly attempted to convince Ms. H that her daughter should not receive life-saving medical care. Ms. H was not persuaded. She continued to request that Baby K receive ventilator support if necessary. The Hospital filed this lawsuit on January 21, 1993.

In its Complaint, the Hospital sought a declaration that it is not required, under five separate statutes, to provide mechanical ventilation and other emergency medical treatment to Baby K because such treatment is allegedly "futile" and "inappropriate." The five statutes cited in the Complaint were the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1988 & Supp. IV 1992); the Americans With Disabilities Act (ADA), 42 U.S.C. § 12112 (Supp. IV 1992); the Child Abuse Amendments of 1984, 42 U.S.C. § 5102 *et seq.* (1988); and the Virginia Medical Malpractice Act, Va. Code Ann. § 8.01-581.20 (1992 & Supp. 1994). The Hospital named Baby K, Mr. K, and Ms. H as defendants. In addition to a declaration, the Hospital also sought an injunction against Ms. H to prohibit her from directing the Hospital and its physicians to provide Baby K with mechanical ventilation and from otherwise interfering with the physicians' decision to withhold or withdraw ventilation and other care from the child.[4]

Following a two-day trial, the district court denied the declaratory and injunctive relief sought by the Hospital. The trial court held that under EMTALA, the Hospital has a duty to

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[4] On January 29, 1993, the district court appointed a guardian *ad litem* for Baby K, as requested by the Hospital. In its Findings of Fact and Conclusions of Law (Pet. App. B15 n.2), the district court made clear that the role of the guardian *ad litem* was to be an independent fact-gatherer and not a surrogate decisionmaker. The court therefore found this guardian *ad litem's* recommendation against treatment to be "irrelevant." Pet. App. B15 n.2. This result is consistent with Virginia law. *Id.*

provide mechanical ventilation treatment to Baby K when she presents to the Hospital in respiratory distress and treatment is requested for her. Pet. App. B6.[7]

The district court also held that the Hospital's failure to provide respiratory support to Baby K because of her disability of anencephaly would constitute discrimination in violation of the Rehabilitation Act and the Americans With Disabilities Act.[8] Pet. App. B9, B10-B11. Finally, the court declined to rule on the application of the Child Abuse Amendments and Virginia law. Pet. App. B11, B12.

On July 23, 1993, the Hospital appealed the district court's decision and requested an initial hearing in banc.[9] The Fourth Circuit Court of Appeals denied the Hospital's in banc request by Order of August 20, 1993.

On February 10, 1994, the court of appeals affirmed the district court. It held that the Hospital is obligated under EMTALA to provide respiratory treatment to Baby K, in accordance with Ms. H's request, when Baby K presents at the Hospital in respiratory distress. Pet. App. A7. Because the

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[7] The Hospital characterizes the district court's ruling as holding that the Hospital has a duty under EMTALA to render even "futile" medical care. Pet. 6. In fact, however, the district court explicitly held (Pet. App. B7) that the use of mechanical ventilation to assist breathing is *not* futile in relieving the *acute* symptoms of Baby K's respiratory distress, which is the emergency medical condition that must be treated under EMTALA. The court of appeals agreed that the relevant condition under EMTALA is Baby K's respiratory distress, not her anencephaly. Pet. App. A9-A10.

[8] The Hospital asserts that the district court's ruling regarding the Rehabilitation Act "ignored" decisions by the courts of appeals for the Second and Tenth Circuits. Pet. 6-7. This assertion is wholly irrelevant to the Hospital's petition because EMTALA is the only statute presented for this Court's consideration. In any event, the Hospital's assertion is also without merit. The district court considered the decisions of both the Second and Tenth Circuits and concluded that those decisions are factually distinguishable from the case at hand because in those cases the parents had *consented* to the withholding of treatment. Pet. App. B8.

[9] Mr. K and the guardian *ad litem* also appealed. The three appellants are petitioners in this case.

appeals court concluded that the Hospital has a duty to provide stabilizing treatment to Baby K under the plain language of EMTALA, it did not address the Hospital's obligations under the remaining federal statutes or laws of Virginia. Pet. App. A1 n.2.

On February 24, 1994, the Hospital filed a petition for rehearing with a suggestion for rehearing in banc. The panel voted 2-1 to deny the Hospital's petition for rehearing. By a vote of 9-4, the court of appeals denied the Hospital's request for a rehearing in banc. Pet. App. C2.

REASONS FOR DENYING THE PETITION FOR WRIT OF CERTIORARI

The decision of the court of appeals is correct, and it does not conflict with any decision of this Court or any court of appeals. This also is a case of first impression that involves an unusual factual situation. Moreover, the sole question presented by the petition is not of such exceptional importance as to justify review by this Court. The petition should therefore be denied.

In its petition for writ of certiorari, the Hospital tries to make this case appear more complicated than it is.[10/] To do so, the Hospital confuses two different provisions of EMTALA, mischaracterizes the case law in an effort to conjure up a "conflict" with the Sixth Circuit where none exists, asserts that the Fourth Circuit's decision conflicts with federal and state law provisions that are actually irrelevant to either EMTALA or this case, and invokes an alleged standard of medical care that has not been shown to exist and that in any event would be preempted. In short, there is no reason for this Court to grant the petition.[11/]

[10/] Petitioners are referred to collectively herein as "the Hospital."

[11/] The court of appeals decided, and the petition for writ of certiorari presents, only the question of the Hospital's duty to provide stabilizing medical treatment under EMTALA. In order for the Hospital ultimately to prevail in this litigation, it would have to establish, under *each* of the five statutes cited in its Complaint, that it is entitled to refuse to provide life-sustaining medical care to Baby K over the objections of her mother. (continued...)

I. THE COURT OF APPEALS CORRECTLY HELD THAT EMTALA REQUIRES EMERGENCY MEDICAL TREATMENT TO SUSTAIN BREATHING.

The Hospital's contention that the language of the Emergency Medical Treatment and Active Labor Act (EMTALA) is replete with "ambiguities" (Pet. 16) is without merit. EMTALA's requirements are clear on their face. The court of appeals properly applied the plain language of EMTALA to the specific facts of this case in accordance with well-established principles of statutory interpretation.[12/] The Hospital's contentions that the court of appeals' decision is "incompatible" with Medicare laws (Pet. 20-22) and Virginia state law (Pet. 22-24) are also erroneous.

A. The Plain Language Of EMTALA Obligates The Hospital To Provide Baby K With Ventilator Support Should She Present In Respiratory Distress.

EMTALA requires that a participating hospital provide stabilizing medical treatment to any person who comes to the hospital with an emergency medical condition.[13/] 42 U.S.C.

[11/](...continued)

Ms. H continues to assert that the Hospital has a duty to provide life-supporting care to Baby K, not only under EMTALA, but also under the Rehabilitation Act, the ADA, the Child Abuse Amendments, and Virginia law. Thus, even if this Court were to grant certiorari and subsequently rule in favor of the Hospital on the question of EMTALA, this case would still need to be remanded for further consideration of the Hospital's obligations under the remaining statutes.

[12/] *See Norfolk & Western Ry. Co. v. American Train Dispatchers Assoc.*, 111 S.Ct. 1156, 1163 (1991); *United States v. Ron Pair Enters. Inc.*, 489 U.S. 235, 241 (1989); *Caminetti v. United States*, 242 U.S. 470, 485 (1917).

[13/] The Hospital has stipulated that it is a "participating hospital" subject to EMTALA. J.A. 469 (Stip. ¶ 4). In addition, it is well-established that EMTALA applies to *all* patients, not just to uninsured patients or those who are otherwise unable to pay for their medical care. *See* Section II.C *infra*. This too is conceded by the Hospital. Pet. 11.

§ 1395dd(b)(1)(A). An "emergency medical condition" is defined in the statute as:

> acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in . . . serious impairment to bodily functions, or . . . serious dysfunction of any bodily organ or part . . ..

Id. § 1395dd(e)(1)(A). "Stabilizing" medical treatment is defined as "such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition" is likely to result. *Id.* § 1395dd(e)(3)(A). EMTALA's legislative history includes a position paper by the American College of Emergency Physicians stating that "stabilization" should include "[e]stablishing and assuring an adequate airway and adequate ventilation." H.R. Rep. No. 241 (pt. 3), 99th Cong., 1st Sess. 26 (1985).

In its Complaint, the Hospital admitted that Baby K would meet each of these statutory criteria if she were brought to the Hospital with breathing difficulty. First, the Hospital admitted that Baby K's respiratory distress would constitute an "emergency medical condition" under the statute. *See* J.A. 23 (Complaint ¶ 39), J.A. 471 (Stip. ¶ 27). Second, the Hospital conceded that, in order to relieve the acute symptoms of respiratory distress and to stabilize Baby K in those circumstances, ventilator treatment would be required. J.A. 24 (Complaint ¶ 40), J.A. 471 (Stip. ¶ 29). Given EMTALA's clear requirements and the Hospital's conforming admissions, the court of appeals properly concluded that stabilization of Baby K's emergency medical condition requires that the Hospital provide respiratory support. Pet. App. A6-A7.

The Hospital now tries to evade its obligation by plucking certain phrases out of EMTALA and claiming that they create "ambiguities" in the statutory language. Pet. 16-18. The Hospital's arguments are unavailing.

First, the Hospital claims that the phrase "as may be required" is "anchored" in an alleged standard of care for anencephalic infants, and that there is no medical standard

"requiring" treatment for a patient with anencephaly.[14] Pet. 16-17. The full statutory language, "such treatment as may be required to stabilize the medical condition," is more logically read to require the provision of such treatment as will be effective in ameliorating the acute symptoms of a medical emergency.

Second, the Hospital focuses on the definition of "to stabilize" and claims that "EMTALA is not triggered" here because Baby K has not been discharged or transferred in an unstable condition. This argument conveniently ignores the procedural posture of this case, which is a declaratory judgment action in which the Hospital as plaintiff has asked for a declaration of its duties *prior to* refusing ventilation treatment to Baby K. In any event, what the Hospital means by its "transfer" argument -- but does not dare say explicitly to this Court -- is that, if Baby K (or any other individual) presents in respiratory distress, the Hospital can avoid liability under EMTALA by letting her die at the Hospital from lack of ventilation treatment, because there would be neither a "discharge" nor a "transfer." Pet. 17. This would be an outrageous result. It is also contrary to the statutory purpose, which is to provide "an adequate first response to a medical crisis" for all patients and to assure "all Americans . . . that a hospital will provide what services it can when they are truly in physical distress." 131 Cong. Rec. 28,569 (statement of Senator Dole), 28,568 (statement of Senator Durenberger) (1985). The court of appeals was thus correct in rejecting the Hospital's proffered interpretation of the statutory language.[15]

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[14] As discussed below (*see* Section III *infra*), Ms. H disputes the Hospital's alleged standard of care.

[15] Subsequent to the decision of the court of appeals, the Health Care Financing Administration (HCFA) published interim final regulations under EMTALA. 59 Fed. Reg. 32086 (June 22, 1994) (to be codified at 42 C.F.R. § 489.24). The court of appeals' conclusion that a "transfer" is not required is consistent with the view expressed by HCFA in the preamble to the regulations:

> Under these provisions, the hospital would be responsible for treating and stabilizing any

(continued...)

B. The Court Of Appeals' Application Of EMTALA Is Consistent With The Purpose Of The Statute.

The Hospital contends that the court of appeals' construction of the statute is contrary to EMTALA's "limited purpose" as an "anti-dumping" law. Pet. 18. This argument is erroneous.

The decision of the court of appeals is consistent with EMTALA's underlying purpose. The Hospital repeatedly states that Congress enacted EMTALA in order to put an end to the practice of "patient dumping." What the Hospital does not mention, however, is Congress's recognition that "dumping" can take many forms. A "dump" might occur for "economic reasons." EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING: HEARING BEFORE THE SUBCOMM. ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS OF THE HOUSE COMM. ON GOVERNMENT OPERATIONS, 100th Cong., 1st Sess. 1-2 (1987) (statement of Representative Weiss). Dumping can be accomplished by "transferring patients to other hospitals, refusing to treat them, or subjecting them to long delays before providing care." H.R. REP. NO. 531, 100th Cong., 2d Sess. 3 (1988); *see also* 136 Cong. Rec. E2466 (daily ed. July 24, 1990) (statement of Representative Stark). Dumping may "involve discrimination on the basis of poverty, race, ethnicity or appearance." EQUAL ACCESS TO HEALTH CARE, *supra*, at 2 (statement of Representative Weiss); *see also* H.R. REP. NO. 531, *supra*, at 3; 131 Cong. Rec. 28,569 (1985) (statement of Senator Kennedy). Most important to this case, a dump can result from a "refusal to treat patients with undesirable conditions." EQUAL ACCESS TO HEALTH CARE, *supra*, at 2. In sum, "[d]umping occurs when you have

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[12](...continued)

> individual, regardless of eligibility for Medicare, who presents himself or herself with an emergency condition at the hospital, and *for providing such care until the condition ceases to be an emergency or until the individual is properly transferred* to another facility.

Id. at 32092 (emphasis added).

something that is undesirable about you. It could be financial or it could be in certain instances medical." *Id.* at 189.

Here, the Hospital seeks permission to deny Baby K emergency treatment because of its determination that her chronic condition of anencephaly deprives her of all quality of life.[16] This, EMTALA does not allow. As Congress specifically recognized, EMTALA prohibits all sorts of "dumps" -- including refusals to treat based on discrimination relating to a patient's medical condition.[17]

The Hospital nonetheless claims that it would not really be "dumping" Baby K by refusing to provide her with emergency care, because Baby K's condition is "fully known" to the Hospital and the Hospital has already devised a "treatment plan" that would not include mechanical ventilation. Pet. 18. What the Hospital wants is court authorization to refuse *acute care* based on a patient's chronic condition. This argument has no support in the language or legislative history of EMTALA. The Hospital's proposal to treat Baby K with only nutrition, hydration, and warmth is not an "adequate first response"[18] to her medical crisis of respiratory distress. Rather, it amounts to no treatment at all for this life-threatening condition, and hence it is a classic "dump."

In a related argument, the Hospital urges a "case-by-case approach" to EMTALA. The Hospital asserts that the statute should be construed to allow physicians to adopt a "case-by-case approach to determine if an emergency episode is governed by EMTALA." Pet. 18. Nowhere in the statute's language or legislative history did Congress indicate that physicians may pick and choose which emergency medical episodes are suitable for stabilization based on their subjective determinations about

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[16] *E.g.*, Brief of Appellants (Fourth Circuit), at 4 ("Her condition deprives her of the essence of human existence . . ..").

[17] In *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990), the Sixth Circuit discussed "reasons other than indigency" that might lead to dumping, including "prejudice against the race, sex, or ethnic group of the patient" and "distaste for the patient's condition (*e.g.*, AIDS patients)."

[18] 131 Cong. Rec. 28,569 (1985) (statement of Senator Dole).

whose life is worth saving. The Hospital's "case-by-case approach" is nothing more than a reprise of its argument to the lower courts that they should read a futility exception into the plain language of EMTALA.[19/]

The court of appeals properly refused to transcend its judicial function by reading such an exception into the statute. Pet. App. A14. EMTALA's plain language mandates stabilization of an "emergency medical condition," defined by the statute as manifesting in "acute symptoms." Pet. App. D7. For Baby K, therefore, the emergency medical condition that must be stabilized is her "apnea, not [her] anencephaly." Pet. App. A10. This condition of apnea may recur from time to time. But recurring episodes of respiratory distress can also occur for individuals with serious illnesses such as cancer, AIDS, or muscular dystrophy, as the court of appeals recognized. Pet. App. A14. Ventilation treatment for these individuals can be effective in stabilizing their emergency condition, even though it will not cure their underlying illness and even though they may ultimately die from their illness. *Id.* As the court of appeals recognized, the statute contains no exception that would allow the refusal of emergency treatment for these individuals. The court of appeals was therefore correct in rejecting the Hospital's argument (Pet. 14) that the term "emergency medical condition" should be deemed inapplicable to acute episodes that may recur during the course of a chronic illness.

C. The Decision Does Not Conflict With Medicare Laws.

The Hospital contends that the decision of the court of appeals places EMTALA in conflict with the requirements of "other Medicare laws." Pet. 20-21. The Hospital's argument

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[19/] Even if EMTALA contained an exception for treatment deemed by physicians to be "futile," that exception would not apply to Baby K. The district court found that mechanical ventilation is *not* "futile" in relieving the acute symptoms of respiratory distress. Pet. App. B7. Indeed, the Hospital continues to litigate this lawsuit precisely because the mechanical ventilation requested by Baby K's mother has been so effective in treating Baby K's incidents of respiratory difficulty.

focuses specifically on 42 U.S.C. § 1320c-5. For several independent reasons, this claim of a "conflict" is specious.[20/]

First, the Hospital distorts EMTALA's relationship to the rest of the Medicare Act. In its essential aspects, EMTALA is meant to impose obligations separate from the Medicare Act.[21/] The independence of EMTALA's requirements from the rest of Medicare law is evidenced, for example, by the fact that EMTALA's protections apply to *every* patient who presents to a hospital in an emergency medical condition, not just to Medicare-eligible patients. *See* 42 U.S.C. § 1395dd(a), (b)(1).

Second, 42 U.S.C. § 1320c-5 is not even mentioned in EMTALA. This fact alone contradicts the Hospital's assertion (Pet. 20) that Congress "specifically incorporated" the requirements of § 1320c-5 into EMTALA. To get around this fact, however, the Hospital claims that the "principles" of this provision are incorporated into EMTALA because peer review organizations (PROs) are generally guided by them, and PROs are referred to in the EMTALA enforcement provisions. But EMTALA itself defines the only duties of a PRO in an EMTALA case: "to assess whether the individual involved had an emergency medical condition which had not been stabilized." 42 U.S.C. § 1395dd(d)(3). In contrast, by its terms, § 1320c-5 applies only to reimbursement decisions for services covered by Medicare payments. It is therefore completely inapplicable to EMTALA.

Finally, pursuant to § 1395dd(d)(3), the PRO provision contained in EMTALA applies only in administrative

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[20/] Although the Hospital dedicates an entire section of its petition to the alleged conflict between EMTALA and 42 U.S.C. § 1320c-5, the Hospital discussed and cited § 1320c-5 in only one sentence, in a footnote, in its 49-page brief to the court of appeals. This previous cursory treatment of § 1320c-5 is at odds with the Hospital's claim that the alleged "conflict" between § 1320c-5 and EMTALA is of such "exceptional importance" as to merit review by this Court.

[21/] EMTALA sits within the broader contours of the Medicare Act because Congress employed its jurisdiction over Medicare-participating hospitals in order to enact legislation which prohibits these hospitals from refusing to screen and stabilize emergency patients.

enforcement proceedings for civil money penalties under subsection (d)(1), and not to litigation between private parties under subsection (d)(2). Thus, PROs have nothing to do with this case.

At bottom, the court of appeals' decision does not place EMTALA in conflict with § 1320c-5 because § 1320c-5 is irrelevant to EMTALA.[22/]

D. The Virginia Health Care Decisions Act Is Inapplicable.

In its petition, the Hospital asserts that the court of appeals' decision "displaces the entire body of state law governing medical decision-making." Pet. 22. The Hospital bases this claim on one provision in one state statute, the Virginia Health Care Decisions Act. As the court of appeals correctly recognized, this statute does not apply to medical decisions on behalf of minors and, even if it did, it would be preempted under EMTALA's preemption provision, 42 U.S.C. § 1395dd(f).

The Virginia Health Care Decisions Act sets out procedures by which an adult can execute an advance directive for his or her medical care, and under which a surrogate can act on behalf of an adult patient who has not executed an advance directive. Va. Code Ann. §§ 54.1-2981 to 54.1-2993 (1991 & Supp. 1994). Section 54.1-2990 of the Act -- which is the basis for the Hospital's entire argument -- states: "Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate." If the physician's treatment decision is contrary to the treatment determination expressed in the patient's advance medical directive, or made by the patient's surrogate, the physician is directed to transfer the patient to another physician. *Id.*

Notwithstanding the Hospital's efforts to bring it into this case, the Health Care Decisions Act is not even applicable here. At the threshold, the Hospital does not have standing to raise

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[22/] The other Medicare laws cited by the Hospital (Pet. 21) are also irrelevant. If EMTALA requires the provision of emergency medical treatment, such treatment cannot be deemed "unnecessary."

§ 54.1-2990 as a claim. This provision of the Act applies by its terms only to "physicians" and not to health care facilities. Since the Hospital is plainly not a "physician," it does not have standing to raise a claim under the statute. *See Lujan v. Defenders of Wildlife*, 112 S.Ct. 2130, 2137 (1992) (quoting *Sierra Club v. Morton*, 405 U.S. 727, 734-35 (1972)) ("[T]he party seeking review [must] be himself among the injured.").

Even if the Hospital did have standing, the Health Care Decisions Act still would not be relevant to this case because the Act does not apply to care involving minors. The Act permits *adult* citizens of Virginia to prepare advance directives for their own future medical care, authorizing a physician to provide, withdraw, or withhold life-sustaining procedures. Va. Code Ann. § 54.1-2983. The Act does not address treatment decisions made on behalf of incompetent minors. As explained in the legislative history:

> The subcommittee recognized the complex problems involved in treatment decisions for terminally ill minors and incompetents. It was agreed that the rights of these patients must be dealt with in a different manner due to the much stronger interests of the parents or guardians and the state in these types of treatment decisions.

Report of the Joint Subcommittee Studying the Rights of the Terminally Ill, House Doc. No. 32, General Assembly of the Commonwealth of Virginia, at 8 (1982). Thus, the court of appeals was correct that the Health Care Decisions Act has no application to respondent Ms. H's request for treatment on behalf of Baby K. *See* Pet. App. A12 n.10.

The court of appeals also was correct in ruling that, even assuming it were relevant to this case, § 54.1-2990 is preempted by EMTALA. Pet. App. A12. EMTALA imposes a duty on both hospitals and physicians to provide stabilizing treatment to an individual in an emergency medical condition where that treatment is requested on the individual's behalf. Since the federal statute requires physicians to provide stabilizing treatment, with no exception for care they may consider "inappropriate," the federal statute directly preempts the state statute's provision on this point. Contrary to the

Hospital's contention (Pet. 24), Congress cannot be expected to add to EMTALA "language that 'directly' conflicts with" every conceivable state law that might bear on medical decisionmaking. A state law that purportedly grants an exemption from a federal statutory obligation is obviously in "direct conflict" with the federal statute and must be preempted.

II. NO CONFLICT OR CONFUSION EXISTS AMONG CIRCUIT COURTS REGARDING THE ISSUES IN THIS CASE.

The Hospital urges this Court to grant its petition because of alleged "confusion" in lower court decisions interpreting EMTALA and because of an alleged "conflict" between this case and two decisions of the Sixth Circuit. None of the conflicts or inconsistencies that the Hospital points to exist, and most of the issues described as areas of confusion are entirely irrelevant to this case.

A. The Fourth Circuit's Decision Does Not Conflict With Decisions Of The Sixth Circuit.

The Hospital argues that the Fourth Circuit's decision in this case conflicts with two Sixth Circuit decisions, *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), and *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990). The Fourth Circuit perceived no such conflict, and in fact cited both cases with approval. Pet. App. A4, A13.

The Fourth Circuit's decision holds that a hospital may not avoid liability under EMTALA by admitting a patient and then simply refusing to treat her. Pet. App. A13. The Hospital contends that, in contrast, *Thornton* and *Cleland* hold that EMTALA is triggered only if a patient is discharged or transferred to another hospital while in an unstable condition.

The Hospital has mischaracterized as "holdings" language in the two Sixth Circuit opinions that provides only a general description of EMTALA's provisions. In both *Thornton* and *Cleland*, the plaintiffs were in fact transferred. Neither case even considered the application of EMTALA to patients who are neither treated nor transferred. Thus, the "transfer" language that the Hospital quotes from these decisions (Pet. 25) simply reflects the background fact that the patients at issue were transferred; it does not constitute a finding or holding that

EMTALA applies *only* if the patient is transferred in an unstable condition. A refusal to treat was simply not at issue in either *Thornton* or *Cleland*.

The thrust of the Hospital's "transfer" argument is that a hospital can avoid EMTALA liability simply by holding a patient such as Baby K in its emergency room, without stabilizing treatment, until she dies. The Hospital argues that it is not "refusing to treat" Baby K because it intends to provide her with nutrition, hydration, and warmth. Pet. 24. But the Hospital explicitly proposes to deny her mechanical ventilation, the only treatment that will allow her to breathe when she is experiencing apnea or bradypnea (abnormal slowness of breathing). This proposal is clearly a refusal to treat the emergency medical condition.

As the Fourth Circuit correctly recognized, Congress intended to prohibit this type of "dump" when it enacted EMTALA. The House Committee on Government Operations observed that patient dumping "can be accomplished by transferring patients to other hospitals, *refusing to treat them*, or subjecting them to long delays before providing care." H.R. Rep. No. 531, *supra*, at 3 (emphasis added). Thus, like *Thornton* and *Cleland*, the Fourth Circuit's decision is aimed at preventing "dumping." Contrary to the Hospital's argument (Pet. 25), there is no conflict here.

The Fourth Circuit perceived no conflict between its decision and *Thornton*; in fact, it cited that case favorably for the principle that hospitals may *not* avoid liability under EMTALA "by accepting and screening a patient and then refusing to treat the patient." Pet. App. A13. As noted by the Fourth Circuit, *Thornton* contains language indicating that a hospital's duty to stabilize does not depend on whether a patient is transferred:

> Once a patient is found to suffer from an emergency medical condition, the hospital must give the patient treatment to stabilize that condition unless the patient can be transferred without danger of the patient's condition deteriorating. 42 U.S.C. § 1395dd(b), (c).

* * *

> Emergency care must be given until the patient's emergency medical condition is stabilized.

895 F.2d at 1134, 1135.[23] Thus, *Thornton* is consistent with the Fourth Circuit's ruling that EMTALA requires such treatment as is necessary to keep a patient alive through a medical emergency until the patient can be safely transferred to another facility or discharged.[24]

In sum, the Fourth Circuit's decision presents no conflict with Sixth Circuit decisions and no inconsistency with the statutory purpose.

B. There Is No Confusion Regarding EMTALA's Requirement To Provide Stabilizing Treatment To A Patient With An Emergency Medical Condition.

The Hospital contends that lower courts are confused regarding the "level of care" required under EMTALA (Pet. 13) and that therefore "[i]t is time for this Court to step in" and clarify the obligations of hospitals under the statute (Pet. 14). In fact, there is no uncertainty as to a hospital's clear duty under EMTALA to provide stabilizing treatment for a patient's emergency medical condition. The only confusion is that manufactured by the Hospital through its misreading of the case law.

EMTALA imposes two separate duties on Medicare-participating hospitals. One provision requires hospitals to provide an "appropriate medical screening examination" to any

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[23] Also consistent with this conclusion is the Fifth Circuit's decision in *Burditt* v. *U.S. Department of Health and Human Services*, 934 F.2d 1362, 1368 (5th Cir. 1991) ("Patients diagnosed with an 'emergency medical condition' . . . must either be treated or be transferred in accordance with EMTALA."). *See also* note 15 *supra* (discussing HCFA's regulations under EMTALA).

[24] Consistent with this purpose, ventilation treatment for Baby K will alleviate the child's medical emergency and allow her to be discharged to the nursing home.

individual who comes to a hospital's "emergency department." 42 U.S.C. § 1395dd(a). Another provision requires a hospital to provide stabilizing treatment to any individual determined to have an emergency medical condition. *Id.* § 1395dd(b). The stabilization provision of EMTALA is the provision at issue in this case. *See* page i *supra*; Pet. i, 8.

The Hospital presents five cases and suggests that they set forth conflicting interpretations of the level of care required by EMTALA. Pet. 13. In fact, four of the five cited cases did not even address EMTALA's stabilization provision, which is the one at issue in this case.[25/] The fifth case discussed both the screening and stabilization provisions, but the statute's stabilization provision was not actually triggered because the hospital did not detect the existence of an emergency medical condition.[26/] In addition, the court there found that "the plaintiff's condition was stable," and "level of care" was not even an issue with respect to the stabilization requirement. Thus, these cases are irrelevant to the statutory provision presented to this Court by the Hospital's petition. Even

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[25/] Three of the cases cited by the Hospital deal exclusively with EMTALA's screening requirement. *See Brooks v. Maryland General Hosp., Inc.*, 996 F.2d 708, 713 (4th Cir. 1993) ("Brooks' EMTALA claim is aimed at disparate screening"); *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992) ("we are not here concerned with any claim that [the] [h]ospital failed to stabilize [plaintiff's] condition"); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) ("[w]e do not in this case address the scope of the stabilization [provision]"). The fourth case, a district court case which is currently on appeal to the Fourth Circuit, addresses whether an award of damages under EMTALA is limited by state tort law. *See Power v. Arlington Hosp.*, 800 F. Supp. 1384, 1385 (E.D. Va. 1992), *appeal docketed*, No. 92-2195 (1st Cir. argued February 7, 1994). To the extent the district court in *Power* discussed the "level of care" issue raised here by the Hospital, it too was addressing EMTALA's screening requirement. *See id.* at 1387 n.6. Thus, none of the four cases is relevant to the EMTALA provision at issue in this case.

[26/] *Cleland*, 917 F.2d at 271.

assuming these cases suggest inconsistencies in interpretation, this Court could not resolve them through this case.[27/]

The Hospital attempts to confuse matters further by suggesting that its duty under EMTALA to provide emergency medical treatment for Baby K's respiratory distress is somehow limited by an alleged "prevailing standard of care" embodied in state malpractice law. The Hospital's "prevailing standard of care" argument fails in the face of evidence that Congress enacted EMTALA in order to develop a federal obligation separate and apart from state malpractice law. The express purpose of EMTALA was to create a federal cause of action for the refusal to treat -- a cause of action traditionally unavailable under state malpractice law. *See* 131 Cong. Rec. 28,569 (1985); *see also Thornton*, 895 F.2d at 1133. As the Fourth Circuit recognized in *Brooks v. Maryland General Hosp. Inc.*, 996 F.2d 708, 710 (4th Cir. 1993):

> Congress expressed concern that hospitals were abandoning the longstanding practice of providing emergency care to all due to increasing pressures to lower costs and maximize efficiency. Under traditional state

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[27/] In any event, the alleged inconsistency among these other cases does not exist. Circuit courts that have considered the issue agree that the "appropriate medical screening" requirement of EMTALA mandates that hospitals provide uniform (non-disparate) screening procedures to all individuals coming to the emergency room. *See Brooks*, 996 F.2d at 713; *Gatewood*, 933 F.2d at 1041; *Cleland*, 917 F.2d at 271; *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 878 (4th Cir. 1992). The one alleged "inconsistent" case cited by the Hospital, *Power v. Arlington Hospital*, is not to the contrary. In fact, in the footnote to which the Hospital cites, the district court in *Power* specifically embraces the uniformity standard for screening. 800 F. Supp. at 1387 n.6.

If a uniformity or non-disparate treatment standard also applied to EMTALA's stabilization provision, the Hospital would still be obligated to provide Baby K with mechanical ventilation. The Hospital states that it is proposing to deny the treatment to Baby K "solely because of her anencephaly." Pet. 19. This illustrates the Hospital's disparate treatment of Baby K as compared with other individuals who might come to the Hospital in respiratory distress.

> tort law, hospitals are under no legal duty to provide this care. Accordingly, Congress enacted EMTALA to require hospitals to continue to provide it.

The thrust of the *Brooks* decision is that malpractice law and prevailing standards do *not* govern or limit a claim under EMTALA. *Id.* at 714-15. As observed by the Fourth Circuit in that decision:

> Congress deliberately left the establishment of malpractice liability to state law, limiting EMTALA's role to imposing on a hospital's emergency room the duty to screen all patients as any paying patient would be screened *and to stabilize any emergency condition discovered.*

Id. at 711 (emphasis added). The Hospital's duty to stabilize Baby K under federal law is clear.

Moreover, although the Hospital's entire petition is based on its assumption that treatment for Baby K is outside a "prevailing standard of care," that assumption is disputed in this case. Neither the district court nor the court of appeals rendered a decision regarding the standard of care under Virginia medical malpractice law. And Ms. H disputes the Hospital's contention that there is an established "prevailing standard of care" not to provide anencephalic infants with emergency care when such treatment is requested for them by a parent. *See* Section III *infra*.

C. Circuit Courts Have Uniformly Held That EMTALA Protects All Patients, Not Just The Indigent And Uninsured.

The Hospital suggests that lower courts have been confused about whether EMTALA protects all patients, or only patients denied care for economic reasons. Although a few early district court opinions held that EMTALA applies only to patients with insufficient resources, every circuit court that has considered the issue has held that the statute applies regardless

of economic motive.[22] The Hospital itself acknowledges that this result is "compatible with the language of the statute and the overall purpose of providing an appropriate first response in a medical emergency." Pet. 11. Since there is no confusion in the case law on this point, there is nothing for this Court to resolve.

D. Lower Courts Agree That EMTALA Requires Treatment Of Patients With Emergency Conditions Anywhere In The Hospital, Not Just The Emergency Room.

The Hospital also alleges confusion among the lower courts concerning whether EMTALA only requires stabilizing treatment for patients in the emergency room, or whether it also obligates hospitals to treat patients who enter the hospital through a department other than the emergency room or who are transferred to another area of the hospital from the emergency room. Pet. 11-12. Again, contrary to the Hospital's allegation, there is no confusion on this issue.

Lower federal courts and state courts are consistent in holding that EMTALA requires the treatment of emergency medical conditions irrespective of the manner in which the patient arrives at the hospital or where within the hospital the patient is located.

EMTALA states that a *screening* must be done for individuals who come to a "hospital emergency department." 42 U.S.C. § 1395dd(a). In contrast, the provision concerning *stabilization* makes no mention of the emergency room at all. The statute's stabilization provision explicitly states that stabilizing treatment must be provided by "the hospital" whenever an individual "comes to a hospital and the hospital determines that the individual has an emergency medical condition . . . ," unless the patient can be transferred without danger of the patient's condition deteriorating. 42 U.S.C. § 1395dd(b),(c).

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[22] *See Gatewood*, 933 F.2d at 1040; *Cleland*, 917 F.2d at 270; *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991); *Collins*, 963 F.2d at 308.

In accordance with this plain language, courts have invariably rejected the argument that EMTALA's stabilization requirement applies only if a patient is in the emergency room. In *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131, 1135 (6th Cir. 1990), the Sixth Circuit established that a hospital cannot evade its EMTALA obligations once it moves an emergency room patient into another part of the hospital:

> Although emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. Hospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital . . ..

The cases cited by the Hospital (Pet. 12) are in total harmony so far as this principle is concerned. Both *Loss v. Song*, No. 89C 6952, 1990 U.S. Dist. LEXIS 13667, at *8-9 (N.D. Ill. Oct. 12, 1990), and *Smith v. Richmond Memorial Hosp.*, 416 S.E.2d 689, 693 (Va.), *cert. denied*, 113 S.Ct. 442 (1992), specifically hold that EMTALA requires hospitals to treat patients with emergency conditions who are in sections of the hospital other than the emergency room. Indeed, both opinions quote the precise language from *Thornton* set forth above. *Id.*

There is also no disagreement among the courts regarding the separate question of whether such patients must have entered the hospital through the emergency room in the first place. The Hospital cannot point to a single case in which a court has denied a patient the protection of EMTALA because he or she came into the hospital through a department other than the emergency room.[29/] As one court has pointedly

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[29/] The Hospital asserts that both *Loss v. Song, supra*, and *Deberry v. Sherman Hospital Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990), held that a patient must allege that he came to the emergency room. The Hospital is incorrect. In *Loss v. Song*, the individual whom the hospital failed to

(continued...)

noted: "[I]t is a ridiculous distinction, one which places form over substance, to state that the care a patient receives depends on the door through which the patient walks." *McIntyre v. Schick*, 795 F. Supp. 777, 781 (E.D. Va. 1992). *See also Smith*, 416 S.E.2d at 692-93.[30]

Johnson v. University of Chicago Hosp., 982 F.2d 230 (7th Cir. 1992), cited by the Hospital to demonstrate the supposed inconsistency among the lower courts as to this issue, is in fact consistent with the other decisions. The question in that case was not whether EMTALA applies when a patient enters the hospital through a department other than the emergency room,

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[29](...continued)

stabilize was an infant born at the hospital. In *Deberry*, the plaintiff alleged a violation of EMTALA's screening provision, which requires that an individual come to the emergency department; *Deberry* does not require that a plaintiff alleging a violation under EMTALA's stabilization provision must come to the emergency room. *See Deberry v. Sherman Hosp. Ass'n*, 769 F. Supp. 1030, 1031 (N.D. Ill. 1991).

[30] The preamble to the recent EMTALA regulations indicates that HCFA also holds the view that emergency treatment must be given regardless of which door the patient entered or where at the facility the patient is located:

> We believe that section 1867 of the Act also applies to all individuals who attempt to gain access to the hospital for emergency care. An individual may not be denied services simply because the person failed to actually enter the facility's designated emergency department. To read the statute in such a narrow fashion would in our view frustrate the objectives of the statute in many cases and lead to arbitrary results. For the same reason, a facility may not prevent an individual from gaining access to the facility in order to circumvent these requirements. If an individual is on a facility's property, . . . and a request is made on the individual's behalf for examination or treatment for a medical condition, we believe the statute reasonably requires the facility to provide a screening examination and treatment or transfer in accordance with section 1867 of the statute.

59 Fed. Reg. 32086, 32098 (June 22, 1994).

but rather whether the statute applies when a patient never comes to the hospital at all. Although the hospital in that case had radio telemetry contact with the paramedics treating the patient, the patient was never present at the hospital itself. The Seventh Circuit held that EMTALA did not apply, but it indicated that it would have found differently if the patient had ever come to "the UCH [University of Chicago Hospital] *or* its emergency department." *Id.* at 233 (emphasis added).

III. THIS CASE PRESENTS NO LEGAL QUESTION OF EXCEPTIONAL IMPORTANCE.

This case involves nothing more than the straightforward application of a federal statute's plain language to a particular set of facts admitted by the Hospital. Nevertheless, the Hospital claims that this case presents a legal question of "profound public importance" (Pet. 15) that warrants review by this Court. The court of appeals twice rejected the Hospital's claim that this case was of "exceptional importance."[31/] This Court should do likewise.

The Hospital's claim of importance rests on several arguments, all of which are unavailing. The Hospital argues that the court of appeals' decision requires hospitals and physicians to provide treatment that "violates" the prevailing standard of care enforced by state law. Pet. 9, 23. The court of appeals did not state that providing respiratory support to Baby K, as requested by her mother, conflicts with a prevailing standard of care.[32/] The district court, after hearing testimony

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[31/] The court denied the Hospital's motion for an initial hearing in banc as well as its suggestion for rehearing in banc. *See* Fed. R. App. P. 35(a).

[32/] The court of appeals did not even suggest that the standard of care would be "violated" by treating Baby K. Nor did the court of appeals determine that treating Baby K would "exceed" the standard of care. Instead, the court of appeals assumed *arguendo* the Hospital's *assertion* that the treatment would be outside the prevailing standard of care, and held that the statute made no exception to the duty to provide stabilizing treatment even if the required treatment would exceed the prevailing standard. *See* Pet. A10-A11.

on this point at trial, made no such finding either.[23] Ms. H continues to maintain that there is no conflict between the court of appeals' application of EMTALA and the prevailing standard of care.

The Hospital also argues that the court of appeals' decision requires "medically inappropriate" care. Pet. 17. In the lower courts, the Hospital argued that treatment of Baby K's respiratory distress is "medically inappropriate" because it is "futile." The district court found that such treatment is not "futile" because it is effective in relieving the acute symptoms of respiratory distress. Pet. B7. The court of appeals did not disturb this finding; moreover, it too recognized that breathing assistance has stabilized Baby K and has allowed her to be discharged to the nursing home. Pet. A3.

The Hospital also implies that, but for the Fourth Circuit's decision, a physician could override a patient's or surrogate's treatment decision based on the physician's view that it is "inappropriate" to maintain the patient's life. There is no medical consensus and no case law to support the Hospital's contention.[24] Indeed, the Hospital concedes this lack of support in a letter to the NEW ENGLAND JOURNAL OF MEDICINE, submitted for publication in response to an article cited in the Hospital's petition (Pet. 4 n.3). The Hospital's letter states:

> Within the medical profession itself there appear to be disputes as to whether physicians must provide medically inappropriate interventions at the end of life

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[23] Ms. H's medical expert, Dr. Byrne, testified that ventilation is the prevailing standard of care for an infant who presents in respiratory distress, and that there is no exception to this standard for anencephalic infants. J.A. 309, 321-23. The Hospital's expert, Dr. McClintock, conceded that the general standard of care for patients in respiratory distress is to clear an airway and that he is unaware of any exception to that standard for anencephalic babies. J.A. 256-57.

[24] *See* Marcia Angell, M.D., *After Quinlan: The Dilemma of the Persistent Vegetative State*, 330 New Eng. J. Med. 1524 (1994); Marcia Angell, M.D., *The Case of Helga Wanglie -- A New Kind of "Right To Die" Case*, 325 New Eng. J. Med. 511 (1991).

> upon the request of a patient or a patient surrogate. Even this Journal has editorialized that families have the right to determine the continuation of life-prolonging treatment against the judgment of the physician and the institution as to the medical appropriateness of the treatment. N. Eng. J. Med., 1991; 325:511.[35]

The Hospital also concedes that "[t]here are no reported cases in which a court has ruled that a physician may, based upon recognized medical standards, override a parent's wish to have life support continue for his or her dying child."[36] Thus, the court of appeals' decision here is consistent with, and not a radical departure from, medical and legal principles.

Even if EMTALA's requirements as applied in this case were to exceed prevailing standards of care, however, the Hospital's warnings about the "reach" of the statute (Pet. 9) are out of proportion to EMTALA's actual effect. First, far from governing the entire practice of medicine, EMTALA applies only to the treatment of patients with "emergency medical conditions" and only to hospitals that participate in the Medicare program. EMTALA has no effect on the treatment of patients outside of such hospitals or on the treatment of conditions other than emergency conditions.

Second, even for hospital patients with emergency conditions, the duty imposed on hospitals by EMTALA is parallel to but distinct from the duty imposed by state malpractice law. As explained above, EMTALA creates a separate federal cause of action for the *refusal to treat* -- a cause of action traditionally unavailable under state malpractice law. *See* Section II.B *supra*. Indeed, the Fourth Circuit has elsewhere made clear that a hospital's obligations under EMTALA to screen and to stabilize a patient are entirely independent from the issue of whether there has been medical

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[35] Letter from Robert S. Chabon, Medical Director of the Hospital, Julia Krebs-Markrich, Counsel for the Hospital in *Baby K*, and Jacquelyn Boyden, General Counsel, to Editor, *New England Journal of Medicine*, at 2 (June 1, 1994).

[36] *Id.* at 1.

malpractice for deviating from the standard of care. *Brooks*, 996 F.2d at 710 ("The Act was not designed to provide a federal remedy for misdiagnosis or general malpractice."). *See also Gatewood*, 933 F.2d at 1041 ("[W]e cannot agree that [EMTALA] creates a sweeping federal cause of action with respect to what are traditional state-based claims of negligence or malpractice."). Thus, if Baby K presents to the Hospital in respiratory distress, EMTALA prohibits the Hospital from refusing to provide her with treatment directed toward stabilizing her emergency condition of respiratory distress. EMTALA does not regulate the competence with which emergency treatment and followup care are provided; those issues are governed by state malpractice law.

Finally, the Hospital itself acknowledges that the court of appeals' decision is not likely to affect significantly its treatment of dying patients.[37/] The Fourth Circuit concluded that there is no exception from EMTALA obligations as to anencephalic, cancer, AIDS, or muscular dystrophy patients, and that all are therefore protected under the statute. In response, the Hospital suggests that all but the anencephalic patient would be eligible for treatment of an emergency medical condition. For example, the Hospital indicates that "it would be medically appropriate to provide" mechanical ventilation to patients with cancer, muscular dystrophy, or AIDS who request such treatment for respiratory distress. Pet. 19. It also asserts that "[i]t is solely because of her anencephaly that Baby K cannot benefit from medical treatment and that physicians do not wish to provide aggressive treatment." Pet. 19. What the Hospital is saying is that the decision's only practical effect is to require the Hospital to provide to an anencephalic child for whom a treatment request is made the same treatment that it ordinarily would provide to other patients in respiratory distress.[38/]

[37/] Ms. H contests the Hospital's characterization of Baby K as a "dying infant," since she has lived for almost two years.

[38/] EMTALA does not require the provision of stabilizing treatment where there is no consent to such treatment. 42 U.S.C. § 1395dd(b)(2).

The court of appeals' decision simply does not have wide-ranging implications for the practice of medicine. For example, between 1987 and 1993, only eight anencephalic babies were born in the Hospital, and the present case is the only one in which a parent requested ventilator treatment.[39] In addition, as observed by an authority relied on by the Hospital (Pet. 4 n.3): "Emergency physicians can live with this rule, because the case is not likely to arise again."[40]

CONCLUSION

For the reasons set forth herein, the petition for writ of certiorari should be denied.

Respectfully submitted,

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[39] Fairfax Hospital's Supplemental Responses to Ms. H's First Set of Interrogatories and Requests for Production of Documents, at 4-6. Contrary to the Hospital's contention (Pet. 28), Ms. H has not asked the Hospital to cure Baby K's anencephaly, and the Fourth Circuit's decision does not require the Hospital to try to do so.

[40] George J. Annas, *Asking the Courts to Set the Standard of Emergency Care -- The Case of Baby K*, 330 New Eng. J. Med. 1542, 1545 (1994).